Commentary:
THE ROLE OF THE CHIROPRACTOR

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Abstract: Chiropractors in Australia face some challenges that are unique in their history. The value of their primary treatment modality is now widely recognised. The process of professionalisation of this occupation is well advanced. Yet the integration of chiropractic services within the mainstream Australian health care system remains problematic. It is contended in this paper that chiropractors' integration will be facilitated by two genuine and strategic moves by the medically minded segment of, or the entire, profession. One is to abandon metaphysical notions as part of the 'philosophy of chiropractic' and the other is to pursue limited prescription rights allowing chiropractors to play fully the role of the primary contact practitioners of neuromusculoskeletal medicine. This development is deemed to be beneficial and appropriate for the profession as well as the patients served by this profession.

Key Indexing Terms: Chiropractic, prescription rights, neuromusculoskeletal, scope of practice.

INTRODUCTION

This paper is a commentary on the current status of the chiropractic profession in Australia. It also proposes, for further development of at least a segment of the profession in this country, the incorporation of a limited range of medications within the scope of their practice. This commentary is addressed to those scientifically minded chiropractors that intend to join the mainstream Australian health care system. The similarities in terms of status, education and practice between the chiropractic and osteopathic professions in Australia are startling. Hence, much of what is proposed here may be directly applicable to medically minded osteopaths as well. Currently a move is underway in osteopathic circles towards greater practice rights incorporating prescription of at least some medications. However, the question of whether the osteopathic profession decides to pursue limited or full practice rights is one for osteopaths themselves. The move towards prescription rights is by no means confined to chiropractors and osteopaths. Optometrists and podiatrists are examples of other professions that either have obtained, or are moving towards obtaining these rights (1).

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Chiropractors in Australia and around the world have begun to evaluate, standardise and refine their clinical art. A healthy debate has begun over the issue of scope of practice (2-4). Attempts have been made in a number of countries including Australia to formulate standards for clinical practice (5). Increasingly, research is being conducted to investigate the value of chiropractic interventions in a variety of conditions (6-8), in an attempt to further clarify our scope. These efforts reflect the chiropractors' re-evaluation of their possible future role within the mainstream health care system.

Historically, chiropractors functioned entirely outside the health care system. Therefore, they learned to rely on their own clinical skills in both diagnosis and treatment. They performed their own radiographic services, relied on their own radiologic interpretation, worked in their own solo or group practices and billed their patients directly. This situation has now changed. In the Australian context, private health insurance plans provide some coverage for chiropractic services; more and more chiropractors now refer their patients out for Medicare-funded radiological services and work in multidisciplinary practices often alongside medical practitioners; and bill government departments for some patient visits. This relative integration of chiropractors into the health care system has inevitably changed, and will continue to change, chiropractic practice. It is time therefore, for chiropractors to identify the role that they want to play within the Australian health care system in the future. Before this can be done it should be appreciated that Australian chiropractic comprises of a number of different camps each with their own point of view and mode of clinical practice. Each of these groups may have different aspirations about their role within the health care system of this country. Therefore a brief examination of the various camps, as the author sees them, is made here.

The Different Camps

Much has been written about chiropractic's two traditional camps. The so-called "straights" and "mixers". "Straight" chiropractors are those who believe in the metaphysical notion that vertebral misalignments impede the mysterious flow of "life force" (9) or "innate intelligence" throughout the body and cause disease, and that manipulation of spinal joints reverses this process. These chiropractors make this belief the foundation of their practice and understandably, they tend to attract those patients who have similar beliefs. It should be conceded that this style of practice clearly satisfies the needs of some patients, even if these needs may be mainly psychosocial. However

putting aside, for the moment, the question of the validity of the assertion underlying the practice of "straight" chiropractic, this belief in the causation of disease is not shared by other members of the health care team in this country. Therefore it cannot serve any meaningful purpose in either our dialogue with other professions or in our practical co-operative efforts in taking care of our patients. There is considerable doubt about whether metaphysical notions should even be part of the philosophy of chiropractic (10) if indeed such a philosophy exists at present (11).

A distinction needs to be made here between the personal religious beliefs of a practitioner, and institutionalised chiropractic spiritual beliefs as substitute-religion. Personal religious beliefs of the practitioner invariably have some impact on the practitioner-patient interaction. This impact would most likely be a positive one in that, in the least, it introduces a standard of ethics and a commitment to this standard by the practitioner, which would be expected to be enviable to those who devise professional ethical standards. However chiropractic is not a religion, and it is indeed a very poor substitute for religion. As a health care occupation, which is open to people of any religious, spiritual, or ideological affiliation, the chiropractic professional package should not include its own system of metaphysical belief. Much can be said in discrediting the "straight" chiropractic view as the philosophical basis for a health care discipline, which is beyond the scope of this paper. It should suffice to say that this view is not only at variance with conventional medicine, it is also at variance with the conventional society in which we operate. It only finds resonance with those who are in the words of Nelson (12) "cultural creatives" who form a very small proportion of the population at large. Given that a great many of high-volume practices represent the "straight philosophy" much of the public has only been exposed to this brand of chiropractic. It is little wonder then that we only get to see a small percentage of people with back pain, who incidentally are the people we can help the most (13). The point should be made that as long as "straight" chiropractors persist with their metaphysical "philosophy" there would be little chance of their incorporation within the health care system. This may not be a problem for this group however, since "straight" chiropractors may not have any intention of becoming part of the mainstream.

"Mixers" are those chiropractors, who in addition to spinal joint manipulation use other forms of treatment. This group is widely believed to represent the majority of the profession. By using other forms of treatment these chiropractors clearly demonstrate their belief in the multifactorial nature of disease. However, within this camp there are two main groups with their own characteristic tendencies. One group is made up of individuals who use a combination of chiropractic methods with naturopathic, homeopathic, and other "alternative medicine" type approaches. Given that some naturopaths continue to use spinal manipulation, members of this group are in practice virtually indistinguishable from those naturopaths. It can be argued quite successfully that the public associates the role of the "alternative GP" with a naturopath rather than a chiropractor. According to the evidence, this is certainly the case in the US (14,15), and there is no reason to suspect that the Australian public's attitude would be any different. Generalist chiropractors base their practice on generic vitalistic philosophies. It can be argued that in this respect they are as "alternative" as their "straight" chiropractic colleagues.

The other tendency within the "mixer" camp is represented by those chiropractors that are conventional and scientific in outlook, and endeavor to use clinical methods that are scientifically based. This does not mean that their diagnostic methods are extremely reliable and accurate or that their treatments are scientifically proven to be safe and effective. It does however mean that these clinical methods, whether diagnostic or therapeutic, are derived from a logical understanding of accepted scientific principles. These chiropractors have no philosophical quarrels with mainstream medicine. Some of them may emphasise the biopsychosocial model of health and disease as opposed to the biomedical model, but so would many in today's conventional medical circles. These chiropractors are the ones who: endeavor to practice an evidence-based brand of chiropractic; seek to be integrated into the mainstream health care system; and would most probably welcome the new responsibilities and privileges that an expanded therapeutic scope of practice would entail. It is the author's belief that COCA best represents these chiropractors.

The Health Care System and Chiropractors

Health care systems generally have rigid hierarchies. Partly for practical reasons, clear lines of command and unambiguous areas of responsibility have been defined. In the context of the Australian health care system, health care workers can be divided into four major groupings that make up the health care hierarchy, namely: "doctors", "therapists", "technicians", and "support staff". These groupings are largely self-explanatory, and the criteria for belonging to them are both clear and rigid.

The "doctors" group consists of general practitioners, physicians and surgeons, dentists, and veterinarians. In order to belong to this group a person needs to have diagnostic and therapeutic competencies sufficient for independent or autonomous practice. Their diagnostic scope within the boundaries of their specialty is relatively liberal. Their therapeutic scope is wide and includes medicine and surgery. These practitioners undertake education of at least five years' duration, at a major Australian university.

In the "therapists" group there are physiotherapists, occupational therapists, speech therapists, and other types of therapists. These therapists' diagnostic competency is limited to a narrow range of conditions and to recognising when a condition falls outside this range. Their therapeutic range is also limited to a narrow range of options excluding medicine and surgery. These individuals are educated in universities (often in former colleges of advanced education) for three to four years.

The "technicians" group includes dental technicians, radiographers, opticians and other similar occupations. These individuals are not required to have any diagnostic or therapeutic competency and their work is largely technical. The people in this group study for the maximum period of three years either at a TAFE college or at a university. In the "support staff' group there are medical secretaries, ambulance drivers, hospital orderlies and others. These individuals are not expected to have any clinical competency and are trained by short courses often at the workplace.

Chiropractic, as currently practiced in Australia, does not fit into any of the above groupings. Chiropractors' education is of five years' duration; their two existing schools are housed within a conventional university without a medical school (Macquarie university) and a former college of advanced education (RMIT); their diagnostic skills are extensive by training and yet limited by practice, and their therapeutic options are limited and exclude medicine and surgery. In these and other respects chiropractors fall between the therapists' and doctors' groups. Since one's role in the system is determined unequivocally by the grouping to which one belongs, this makes the chiropractor's role ambivalent. Therefore, chiropractic's integration into the system is made impracticable and unworkable.

There is, and naturally so, a constant on-going attempt by the various health occupations to rise to higher levels in the health care hierarchy. Optometrists in Victoria, in addition to their traditional therapist role, are going to prescribe therapeutic medications for a variety of eye diseases. This clearly elevates them to the "doctors" group. Physiotherapists are making a concerted effort to enter private practice and act as primary contact practitioners. Podiatrists have extended their three-year undergraduate course to four years. Nurses have moved into universities and upgraded their education to degree level. Some nurses have become "nurse practitioners" and are able to use certain medications and perform certain medical procedures. Some radiographers have entered the field of "radiotherapy". These activities by the various health care occupations, most of which have educational standards lower to those of chiropractors, should highlight to the chiropractic profession the advantages of moving up the health care "corporate ladder".

Since it would clearly be preferable for chiropractors as a group to belong to the highest possible segment of the health care hierarchy, in keeping with their educational standards and clinical competencies, it would be wise for them to take decisive steps to join the "doctors" grouping. This can only be achieved by a deliberate and concerted effort to refine our diagnostic skills; enhance our therapeutic competency; upgrade our education to include those pharmaceuticals useful in chiropractic practice; and abandon our inherited quasi-philosophical beliefs that do not or can not contribute to chiropractic medical science or practice.

It may not be necessary for all, or even the majority of chiropractors to seek prescription rights. Too often in the past the various factions of the profession have attempted to force their viewpoints on the entire chiropractic community. However, the profession is maturing, and one sign of maturity is the ability to not only tolerate diversity of views and practices but to appreciate such diversity. This diversity within chiropractic would be desirable since it would result in creation of real vocational options for the chiropractic student. It would be entirely reasonable for some chiropractors to concentrate on manual and physical means of treatment, while another group of chiropractors would, subsequent to appropriate training, incorporate scientifically based botanical medicine into their practice. In the same way, another group of chiropractors could add counseling or acupuncture-type stimulation to their therapeutic scope. Each of these special interest groups would not only be required to meet an acceptable educational standard, but would also need favorable legislation for their members to be able to utilise these additional modalities. One logical possibility for these groups would be to ultimately develop into chiropractic specialty colleges. Other "limited medical" fields such as dentistry and psychology could serve as models for future development of our profession. In the field of psychology for instance we find counseling psychologists and clinical psychologists each with their own specialised training and skills.

It is contended here that it would be entirely logical for medically minded chiropractors, as a special interest group, based on the neuromusculoskeletal orientation of their undergraduate education; their conventional leanings towards evidence-based or at least scientifically-based practice; and their specialised skills in diagnosis and management of neuromusculoskeletal (NMS) conditions augmented by clinical experience; to move further in the direction of becoming a "limited medical profession". In fact, some have suggested that this is the most likely outcome for chiropractic in general (16). It is also this author's contention that chiropractors' prescription of relevant pharmaceuticals is consistent with the needs of patients with painful spinal and other musculoskeletal conditions, and that this development is achievable without

major changes to our undergraduate education or our mode of practice. Other special interest groups need to convince themselves, governments and the public at large that they are, or will be subsequent to further training, competent in performing additional tasks that relate to their area of interest, and that such developments are consistent with the needs of society.

The move to embrace that part of clinical medicine, which is complementary to chiropractic practice, may create in the future what may be called "chiropractic medicine" or "chiropaedics". A definition of chiropractic medicine as used in this paper is needed since this term has been used by some American chiropractors in the past to describe a practice that is essentially a substitute for general medical practice. A move towards primary care or unlimited practice rights, meaning general medical practice by chiropractors would be futile, since there is no social need in Australia for chiropractors to become general practitioners. General practitioners and family physicians here, already play that role quite adequately. Besides, chiropractic education whilst extensive has a strong neuromusculoskeletal focus and has significant deficiencies in many other areas pertinent to general medicine (4). Chiropractors' greatest contribution to health care in Australia is in their true area of expertise, namely the care of neuromusculoskeletal (meaning musculoskeletal and peripheral nervous system) problems. Hence, it would be logical to build on this strength, rather than seek to duplicate other services (2).

What is meant by chiropractic medicine or chiropaedics in this paper is the diagnosis and management of NMS conditions by manual, physical and medical means. In other words, our current chiropractic and physical treatment modalities plus the use of anti-inflammatories, analgesics, and perhaps some muscle relaxants and anaesthetics. Those chiropractors who choose to enter the field of chiropaedics will be in a position to play a more advanced role within the system, namely that of primary contact practitioners of neuromusculoskeletal medicine. This role will be similar to that of dentists or Victorian optometrists.

What Role Do We Play at Present?

Historically and at present, patients have direct access to chiropractors in Australia. However, this access is in reality limited for a number of reasons. First and foremost among factors that restrict patient access to chiropractic services is the lack of Medicare coverage. There is reason to believe that this is a very significant obstacle and that in its absence the chiropractors' market share would increase significantly. Also for Veterans' Affairs patients a medical referral is required before cover is provided. This clearly limits direct patient access to chiropractors. Direct patient access has always been a critical factor in the eyes of chiropractors regardless of their philosophical orientation. This may well in the future come under increasing threat from government departments and also from the private insurance industry in the form of health maintenance organisations and preferred provider organisations (HMOs and PPOs) as in the United States.

This threat would partly be justified by the limitations of our present role. These limitations include our restricted diagnostic capability due to our extremely limited access to diagnostic facilities; our limited therapeutic scope because of our inability to prescribe medications; and our inability to co-ordinate our patients' care when they need referrals to relevant medical specialists, or when they need to be hospitalised for diagnostic or therapeutic procedures. These limitations result in a chiropractor being only able to play the role of a therapist. However, chiropractors are not formally part of the health care system. They are excluded from hospitals, are not members of rehabilitation teams, and do not receive a significant amount of referrals in private practice from the medical profession. Hence even their limited 'therapist' role is restricted and marginalised. This marginal therapist role, combined with the chiropractors' extensive and rigorous university training, and their conventional orientation amounts to occupational stress, feelings of alienation, limited income, and significant frustration for medically minded chiropractors.

Reasons for Seeking Prescription Rights

There are many reasons for chiropractors to seek limited prescription rights. These reasons may be categorised as legal; clinical; philosophical; educational; politico-economic; and societal.

Legal Rationale

Many chiropractors have discovered the usefulness of over-the-counter analgesics and anti-inflammatories such as Panadol, Nurofen, or Voltaren in combination with chiropractic care and routinely recommend the use of these medications to their patients who suffer from acute pain and/or inflammation. From a strictly legal point of view, such recommendations may be deemed beyond the scope of chiropractic practice. Hence, in the case of any undue reactions to these medications by the patient, the chiropractor would be in part liable, even though these medications are not formally prescribed by the chiropractor, and the patient can buy them off a supermarket shelf themselves. Upgrading the pharmacology training of chiropractors to help them prescribe these, and more potent, medications more safely and more effectively, would eliminate this legal vulnerability of the profession.

Clinical Rationale

Pharmacotherapy would be a good therapeutic adjunct for chiropractors and would enhance their ability to deal with NMS conditions, especially in the acute stages of their presentations (17). There is evidence that many patients opt for co-management of their painful spinal condition by a chiropractor and a general practitioner, with or without the knowledge of the practitioners concerned, in order to achieve optimal relief (18). In caring for acute cases in which over-the-counter medications would prove to be ineffective, chiropractors have no choice but to refer the patient to a general practitioner who would then prescribe the medication required. This creates many real and potential problems in patient care. Firstly a medical practitioner needs to be readily available; secondly this doctor who more often than not has little expertise in orthopaedics needs to be convinced of the appropriateness of co-treatment of the patient by a chiropractor; thirdly the doctor again due to the limitations of his or her general medicine training may make recommendations to the patient that may contradict those of the chiropractor, and subsequently result in harm to the patient. For these and other similar reasons this exercise represents at best, a waste of time for the patient, the doctor, and the chiropractor, as well as resulting in reduction of the cost effectiveness of the process. A mechanism whereby the chiropractor prescribes the appropriate medications would eliminate this inefficiency of the health care system in Australia. Ultimately, chiropaedists would be able to successfully lobby for an enhanced role within the system, allowing them to co-ordinate the care of their patients. This would involve referral rights to medical specialists, diagnostic imaging, and clinical laboratory facilities.

Chiropractic medicine as outlined above represents a clear scope of practice and as such has the potential to be readily integrated into the health care system. By timely and appropriate use of relevant pharmaceuticals, chiropaedists would demonstrate in practice that their philosophy of health and disease and their mode of clinical decision-making are compatible with those of conventional medicine. This in itself would go a long way towards integration of chiropaedics into the mainstream health care system.

Philosophical Rationale

Addition of appropriate medications to our therapeutic repertoire would make our care more comprehensive. A patient-centred outlook is entirely consistent with the call for development of chiropaedics. Chiropaedics would represent competent, comprehensive, and accessible care for patients with NMS conditions, incorporating the best of manual, physical, and medical means of diagnosis and treatment. Patients deserve no less.

Moreover, scientifically oriented chiropractors would have access to another therapeutic option that is rigorously researched and evaluated. The potential for chiropractic research enhanced by our ability to use these pharmaceuticals in clinical settings is enormous.

Educational Rationale

Adoption of the use of medications would strengthen our primary contact status. It would better than ever justify our high educational standards. It would result in increased research opportunities and research funding from government and the pharmaceutical industry.

Politico-economic Rationale

Chiropractors have traditionally functioned as independent practitioners of manipulative therapy. This role proved adequate and sustainable as long as the medical establishment considered this therapy unworthy of adoption. Recently, this situation has changed. Not only the mainstream medical establishment has accepted the clinical value of manipulative therapy (19,20), but it has taken major steps to take over its practice. Physiotherapists and medical practitioners have commenced training in this therapy (21) and increasing numbers of these graduates are entering the marketplace. There is no doubt that political medicine is attempting to replace chiropractors and osteopaths with manipulative physiotherapists and doctors practicing musculoskeletal medicine.

At present, due to their clinical expertise, chiropractors can comfortably compete with manipulative physiotherapists. However, this is not the case in relation to manipulative/ musculoskeletal doctors. If chiropractors wish to remain competitive with still small but steadily growing numbers of musculoskeletal doctors, they need to embrace and adopt those aspects of clinical medicine that are relevant to chiropractic practice. This would not only ensure chiropractic's survival as a clinical discipline, but would also ensure its development into an independent primary contact specialty much like dentistry.

The wholesome practice of chiropractic medicine would establish those chiropractors as the primary contact, portal of entry practitioners for NMS conditions, and would offer them a distinct advantage over general practitioners, or family physicians with respect to this specialised area of expertise. In this way chiropractors would build on their current expertise and their present competitors in the medical community could concentrate on their strengths which in the broad field of internal medicine. Moreover, in this arrangement chiropractors would no longer be in direct competition with manipulative physiotherapists, naturopaths and masseurs, and would have created for themselves a more solid a more sustainable and a more

financially viable future within the health care field. Ultimately as alluded to above this option would significantly expand employment opportunities for chiropractors with positions becoming available in public and private hospitals and community health centres. Indeed the Layton inquiry in 1986 for expansion of Medicare funding commented that a major reason for their inability to recommend public funding for chiropractic services in general was the profession's continued claim to treat 'type O' conditions (22).

Societal Rationale

The enhanced role of a chiropractor would clarify the clinical identity of chiropractors in the eyes of their patients. This in turn, would increase these patients' respect and confidence in their chiropractors, and would most likely result in better compliance. The prestige of the profession will be further enhanced and chiropractors, like dentists, would no longer be required to justify their use of the title "doctor".

CONCLUSION

The chiropractic profession in Australia is at a critical junction in its development and is facing new challenges. The chiropractic community in this country is not homogenous and therefore the different factions of the profession would tend to respond to today's challenges differently. It is proposed in this paper that the medically minded faction of chiropractic should make a concerted effort to broaden its therapeutic scope by pursuing limited prescription rights. It is asserted that this move is logical, practicable, economically and professionally sound and most importantly, beneficial to our patients. Such a change, if achieved, would enhance the role of the chiropractor in the management of neuromusculoskeletal conditions. That in turn, would rationalise patient care and facilitate chiropractors' integration into the health care system. Other segments of the chiropractic profession may in time choose to follow suit in which case the necessary additional pharmacology training may become part of the undergraduate curriculum. The alternative possibility would be for those segments of the profession who have no interest in the model proposed here, to develop their own style of practice and face their own challenges in their effort to survive and thrive in present day's Australian health care environment.

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